Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
REGIONAL PLASTIC SURGERY CENTER

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 08, 2013

Respondent Name
EMPLOYERS INSURANCE COMPANY

MFDR Tracking Number
M4-14-0475-01

REQUESTOR'S POSITION SUMMARY

Requester's Position Summary: "Spoke to Stephanie, she said we are out of netw w/Liberty HCN, but there was a note on patients account that they would process if pt seen before 1-25. She is sending back to see if it will pay, but we will need auth next time."

Amount in Dispute: $769.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter acknowledges receipt of your Network (HCN) complaint on January 15, 2014. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint. Your issue will be forwarded to the appropriate department for further handling. They will investigate the matter and provide you with a written response within thirty (30) days of the receipt of your complaint."

Response Submitted by: Liberty Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
January 24, 2013	99203, L3808-RT, L3808-LT, 73110-FA and 73110-F5	$769.00	$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307, 37 TexReg 3833, applicable to medical fee disputes filed on or after June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

FINDINGS AND DECISION

Issue

1. Did the requestor meet the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 to file for medical fee dispute resolution?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to apply Texas Labor Code statues and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution of the facility services provided. The following are the Division's findings.

1. Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   Texas Insurance Code Section 1305.103 requires, in pertinent part, that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network."

   The requestor has the burden to prove that it obtained the appropriate approval from the certified network for the out-of-network care it provided. The requestor submitted insufficient documentation to support that that an out-of-network referral was obtained from the injured employee's treating doctor and approved by the certified network pursuant to Section 1305.103, thereby failing to meet the requirements of Texas Insurance Code Section 1305.006(3).

2. The requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 7, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).